HEALTH PARTNERS-DENTAL ACCESS INC.

DENTAL CLINIC AFFILIATION CONDITIONS

The Dentist affiliation and Clinic accreditation is conditioned on your acceptance of and compliance with the terms below:

a. render dental services to the members of HPDAI accounts based on the agreed rates to be provided in our proposal letter and Memorandum of Agreement.
b. give preferred discounts to members availing services not included in the member's dental plan.
c. allow his/her name be included in the dental publication, list of clinics and other marketing materials
d. accept that this Agreement is good for 1 year and automatically renewed thereafter unless sooner terminated by either party thru written notice 30 days after the receipt of such,
e. render dental service to HPDAI accounts, its affiliates and tie-up with different organization and its products.
f. all dentists willing to hold all information in the MOA with strict confidentiality

Please print and sign this form if you agree to the above terms and conditions of accreditation.

Signed:

Dr. _____
(Signature over Printed name)

Date signed: _____
PRC license #: _____
Contact #: _____

2F Elysium Bldg., 168 D. Tuazon cor. NS Amoranto St., Quezon City
☎ (632)7110020 / (0922) 842-45-14; (0917) 538-51-11;
Toll free: 1-800-10-7439210
hpdac@yahoo.com / www.healthpartnersdental.com

HEALTH PARTNERS-DENTAL ACCESS INC

Date: _____

DR. TEDDY C. GONZALES
Managing Director
HEALTH PARTNERS DENTAL ACCESS, INC.

Dear Doctor:

RE: **LETTER OF INTENT**

I am writing to request your kind consideration on my application as one of your accredited dentists.

I. How did you learn of HEALTH PARTNERS DENTAL ACCESS, INC.
II. Introduce your practice here to include the following:
    - Brief background of your practice
    - length of time you are practicing
    - specializations if any
III. Clinic profile
    - location, equipments, number of chairs, target market, existing clients
IV. Services offered

I attached my updated Curriculum Vitae and all pertinent documents you have required for this accreditation.

I look forward to your favorable response to my request.

Sincerely yours,

Dr. _____
(Signature over Printed name)

Date signed: _____
PRC license #: _____
Contact #: _____

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HEALTH PARTNERS-DENTAL ACCESS INC.

1 x1
RECENT
PHOTOGRAPH

Please complete all details on the spaces provided on this Clinic Information sheet.

CLINIC INFORMATION SHEET

CLINIC NAME (DTI REGISTERED NAME/ BIR TRADE NAME):			
CLINIC OWNER:			
	(LAST NAME)	(GIVEN NAME)	(M.I.)
SPECIALIZATION:			
PRC LICENSE NO.:		TIN NO.:	
TAX TYPE:	( ) NON-VAT	( ) VAT	
HMO ACCREDITATIONS:			
CLINIC ADDRESS:			
PHONE NUMBER/S:		MOBILE NUMBER:	
		EMAIL ADDRESS:	
CLINIC SCHEDULE:			
NUMBER OF CHAIRS:	( ) by appointment	( ) first come first serve	

ASSOCIATE DENTIST/S:

(LAST NAME)	(GIVEN NAME)	(M.I.)	PRC LIC #	SPECIALIZATION

CLINIC SECRETARY/ DENTAL ASSISTANT

ACCOUNT DETAILS

BANK ACCOUNT NAME:	
BANK ACCOUNT NUMBER:	
BANK NAME:	BRANCH:
( ) SAVINGS	( ) CURRENT

DENTIST SIGNATURE OVER PRINTED NAME

PLEASE ATTACH LOCATION MAP OF CLINIC AND PLEASE FILL UP 1 FORM PER BRANCH.